



Dear Beneficiary:

On the back of this letter is a **Beneficiary Complaint** form. You may file a complaint when you have problems obtaining medical care, are denied a covered Medicaid or Children's Special Health Care Services (CSHCS) benefit, have problems with your health plan, or if you receive bills you feel Medicaid or CSHCS should have paid. You may file a complaint by doing one or all of the following:

- Complete the form on the back of this letter and mail it to the address shown below.
- If you are enrolled in a health plan, you may call the toll-free number shown on your Medicaid ID Card or your health plan ID card. Tell your health plan you want to file a complaint.
- If you receive a denial, reduction, or termination in medical benefits, you have the right to request an administrative hearing. You may call **1-888-367-6557** to get a copy of form **DCH-0092** (Request for an Administrative Hearing).

**If you decide to use the form on the back of this letter, follow the instructions below:**

### INSTRUCTIONS FOR COMPLETING THE FORM

#### SECTION ONE:

Complete each box in this section in its entirety or have someone help you. If you want us to contact someone other than yourself, print that person's name in the Name of Contact Person. Also, be sure to enter the best days and times to contact you.

#### SECTION TWO:

Describe your complaint. Provide a description of your situation. Include important details like dates, times, persons, places, and phone numbers. Attach **copies** of any proof or records that support your complaint, (e.g. copies of bills, letters, statement of services, etc.) Be sure the documents are readable.

#### SECTION THREE:

List the steps that you have already taken to resolve this complaint yourself. Give the names and phone numbers of persons you have called and what information you received from them. Include dates of phone calls. Include copies of any letters you have written and any written responses you may have received. Describe everything you have done to fix the problem yourself.

#### SECTION FOUR:

Tell us what you would like us to do to correct the problem for you. Be specific.

#### SECTION FIVE:

If you had someone else fill out this form for you, have that person **print** his or her name and relationship to you (e.g. spouse, parent, friend, etc.) and sign and date the form. You (as the Medicaid Beneficiary or the parent/guardian of the beneficiary) must also sign and date this form. Mail the completed form in the enclosed postage paid envelope to:

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
MEDICAL SERVICES ADMINISTRATION  
PO BOX 30470  
LANSING MI 48909-7979**

If you have questions about this form or our process, call the Beneficiary Help-Line at **1-800-642-3195**.

Authority: Title XIX of the Social Security Act Completion: Is VOLUNTARY	Penalty: NONE
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The Department of Community Health is an equal opportunity employer, services, and programs provider.
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# BENEFICIARY COMPLAINT

Michigan Department of Community Health  
Medical Services Administration

## GENERAL INSTRUCTIONS:

- See the Reverse Side for Complete Instructions.
- Print clearly and complete all Information.

## SECTION 1 – To be completed by beneficiary or authorized representative:

Beneficiary Name	Beneficiary Date of Birth	Telephone Number (      )
Beneficiary Medicaid or CSHCS ID Number	Beneficiary Medicaid Case Number	
Name of Contact Person	Best Days and Times to Call	

## SECTION 2 - Describe your complaint. Attach additional pages if necessary.

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## SECTION 3 - What have you already done to try to solve this problem? Attach additional pages if necessary.

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## SECTION 4 - What would you like us to do to correct the problem?

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<b>SECTION 5</b> – Name of the person completing this form (if other than the beneficiary)	Relationship to beneficiary
Signature of person completing this form (if other than the beneficiary)	Date Signed
Signature of Beneficiary or Parent/Guardian	Date Signed